



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

SHANNON MEDICAL CENTER  
3255 WEST PIONEER PKWY  
ARLINGTON, TX 76013

#### **Respondent Name**

SERVICE LLOYDS INSURANCE CO

#### **Carrier's Austin Representative Box**

42

#### **MFDR Tracking Number**

M4-12-2373-01

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "We originally billed for this date of service on 04/04/2011, which was well within the 95 day time frame. The first date of submission was via mail on 04/04/2011, which we have attached our system notes to validate this. We also received a send back letter from Corvel requesting box 14 be filled in for this claim to process thru the system. We faxed the corrected claim in the next day as requested. We submitted this claim well within the 95 day deadline from the date of service and also sent the corrected claim the very next day after receiving a request from Corvel!"

**Amount in Dispute:** \$354.20

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "...Shannon Medical Center of San Angelo has filed an MDR Request seeking to have the Division find that it complied with the 95 -day requirement contained in Tex.Labor Code, Sec. 408.027, in effect since Sept. 1, 2005 in Texas workers' compensation claims...Further and as background for the benefit of Shannon's agent, HEALTHCARE RECOVERY ALLIANCE, the 95-day rule carries with it the obligation to complete the required information on its reimbursement request ('the bill') to include all information called for, including the ADMISSION-TYPE. This is box 14 on the required form...What Shannon claims is that it somehow furnished Box 14 information to SERVICE via its UR agent, CorVel in time to comply with the 95-day requirement or approximately June 25, 2011...Looking at what seems to be part of this alleged correction and fax resubmission with Box 14, it shows a July 21, 2011 date, not April. (Attachment 4) There is not physical proof to support the claim by SHANNON through its agent, HEALTHCARE RECOVERY ALLIANCE that it resubmitted the bill with Box 14 information within the 95 day limitation. All evidence, attached, shows the information was furnished in July, outside the late June cut-off."

**Response Submitted by:** Harris & Harris, P.O. Box 91569, Austin, TX 78709

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 22, 2011	Outpatient Services	\$354.20	\$0.00

## ***FINDINGS AND DECISION***

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §102.4 sets out the rules for Non-Commission Communications.
4. 28 Texas Administrative Code §134.204 sets out the guidelines for reimbursement of Workers' Compensation Specific Services provided on or after March 1, 2008.
5. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
6. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:  
Explanation of benefits dated July 28, 2011
  - 25-Separate E&M Service Same Physician
  - B15-Procedure/Service is not paid separately
  - RM2-Time limit for filing claim has expired
  - 29-Time limit for filing claim/bill has expired

### **Issues**

1. What is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Did the requestor forfeit the right to reimbursement for the services in dispute?

### **Findings**

1. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95<sup>th</sup> day after the date the services are provided." No documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the requestor in this dispute was required to submit the medical bill not later than 95 days after the date the disputed services were provided.
2. Texas Labor Code §408.027(a) states, in pertinent part, that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §102.4(h) states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." Review of the submitted information finds no documentation to support that a medical bill was submitted within 95 days from the date the services were provided. Therefore, pursuant to Texas Labor Code §408.027(a), the requestor in this medical fee dispute has forfeited the right to reimbursement due to untimely submission of the medical bill for the services in dispute.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

## ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

05/25/2012  
\_\_\_\_\_  
Date

***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**